RECEIVED
NOV 2010
OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING _____ B. WING _____	10/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey was conducted 10/26/10 through 10/29/10 to determine the facility's compliance with Federal requirements. The facility failed to meet requirements for recertification with the highest S/S of "D".	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the Plan of Correction within this timeframe should in no way be construed or considered as an agreement with	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Norma J. Davis — TITLE: Administrator — (X6) DATE: 11/17/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING _____ B. WING _____	10/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to immediately notify the physician of a significant change in physical status for one resident (#9), in the selected sample of 24, related to an episode of choking that required the Heimlich maneuver. Findings include: A review of the policy/procedure "Physician Notification", revised June 2009, revealed a physician notification form is used for a non-emergency physician update. The policy revealed the physician should be called with a change in condition. A record review revealed Resident #9 was admitted to the facility on 05/09/06, with diagnoses to include Oropharyngeal Dysphagia, Respiratory Distress, Anxiety, Depression, Psychosis, and Drug Abuse. A review of the annual Minimum Data Set (MDS), dated 08/02/10, revealed the facility identified Resident #9 as moderately cognitively impaired and required set up assistance with meals. A review of the Speech Therapy Notes, dated 09/10/10, revealed Resident #9 was referred to speech therapy as a result of weight loss, decreased intake, and two choking episodes. A review of the Nursing Progress Notes, dated 09/21/10 at 6:00 PM, revealed the resident was found choking while eating a meal in his/her room. The note revealed Resident #9 was not	F 157	the allegations of noncompliance or admissions by the facility. 1. On 10/28/10 Resident Identifier #9's physician was notified of the choking episode that occurred on 9/21/10. 2. On 11/8/10, the center's RN Unit Managers reviewed all nurses notes for the past 90 days on all in-house residents to identify any accidents involving residents which result in injury and have the potential for requiring physician intervention; any significant changes in resident's physical, mental, or psychosocial status; any needs to alter treatment significantly; or any decisions to transfer or discharge a resident from the center. Physician's were notified of any identified issues requiring physician notification. 3. Beginning 10/28/10 and continuing through 11/16/10, all licensed nurses were re-educated by the Director of Nursing and the Education and Training Director on the requirement to notify the resident's physician of any accidents involving residents which result in injury and have the potential for requiring physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING _____ B. WING _____	10/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 able to talk and was gasping for air. The Heimlich maneuver was utilized which enabled the resident to breathe and talk. There was no evidence provided or documented in the resident's record indicating the physician was notified. Interviews with Licensed Practical Nurse (LPN) #1, on 10/28/10 at 10:00 AM and on 10/29/10 at 9:30 AM, revealed she was the nurse who performed the Heimlich maneuver on Resident #9. She revealed the resident was pale blue in color and could not speak. After one thrust, the resident was able to breathe. LPN #1 failed to notify the resident's physician and stated, "It was the end of my shift." She revealed the episode was not documented on the 24 hour shift report, but should have been. She stated, "I would definitely notify the physician if something like this were to ever happen again." An interview with the Director of Nursing (DON), on 10/28/10 at 12:50 PM, revealed she expected to be notified if a choking episode occurred at the facility. She revealed she was not notified of the episode on 09/21/10. She stated, "Speech therapy should have been notified of the episode, but not necessarily the physician." An interview with the resident's physician, on 10/28/10 at 11:40 AM, revealed she was not aware of any choking incident involving Resident #9 and requiring the Heimlich maneuver. She revealed she expected to be notified of any instance when a resident required such an intervention.	F 157	intervention; any significant changes in resident's physical, mental, or psychosocial status; any needs to alter treatment significantly; or any decisions to transfer or discharge a resident from the center 4. Unit managers, Director of Nursing, and/or Assistant Director of Nursing will review all nurses notes daily five days a week for 2 weeks, then 3 days a week for 2 weeks, then weekly for 4 weeks to ensure physicians are notified of any accidents involving residents which result in injury and have the potential for requiring physician intervention; any significant changes in resident's physical, mental, or psychosocial status; any needs to alter treatment significantly; or any decisions to transfer or discharge a resident from the center. Any identified non-compliance with requirement will result in one on one re-education followed by disciplinary action up to and including termination for any subsequent non-compliance with requirement. Results of audits will be forwarded to QA committee monthly for review and further recommendations.	11/17/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 10/26/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.